Exhibit 2

Charter
COMMUNICATIONS

Charter Communications, Inc.

Long-Term Disability Program

(a Component Program of the
Charter Communications, Inc.
Welfare Benefit Plan)

Summary Plan Description

Effective January 1, 2017

Table of Contents

INTRODUCTION

This booklet summarizes the provisions of the Charter Communications, Inc. Long-Term Disability Program (the "Long-Term Disability Program"), a component program under the Charter Communications, Inc. Welfare Benefit Plan (the "Plan"), effective as of January 1, 2017. This booklet serves as the Long-Term Disability Program's Summary Plan Description ("SPD"), and describes the benefits and basic provisions of coverage as they apply to eligible Employees (as defined in this SPD and the attached Certificate of Coverage).

Disability insurance provides individuals and their families with financial protection. The Long-Term Disability Program described in this SPD can help secure your family's financial security in the event of your disability.

We encourage you to read this SPD carefully. If you have questions about your eligibility or coverage under the Long-Term Disability Program, you may contact the Charter Benefits Center at 877-892-2367.

This SPD is not the insurance contract. It provides important information about who is eligible for coverage under the Long-Term Disability Program and when coverage begins. It also provides general information about the Plan and your rights under ERISA. The SPD does not alter or waive any terms of the insurance contract. The Certificate of Coverage issued by the Long-Term Disability Program's insurer, Liberty Life Assurance Company of Boston (or simply "Liberty") is attached to this SPD. If you have any questions about your benefits or a claim for benefits, please contact Liberty at its Administrative Office at 9 Riverside Road, Weston, MA, 02493. Claims for benefits under the Long-Term Disability Program should be submitted to Liberty.

Note, also, that the SPD is only a summary of your disability benefits under the Long-Term Disability Program. Additional details of the Plan are contained in the Plan document. Additional details about long-term disability coverage and benefits are described in the Liberty group insurance contract issued to Charter and in the attached Certificate of Coverage (subject to the additional information described in this SPD regarding the employees who are eligible for coverage and when their coverage begins). Where the terms of the Plan document are silent or less specific with respect to an issue addressed in this SPD or Liberty's group insurance contract or Certificate of Coverage, or where the Plan document incorporates by reference certain provisions in this SPD or Liberty's group insurance contract or Certificate of Coverage, such terms of this SPD or Liberty's group insurance contract or Certificate of Coverage, as applicable, shall control. Where the Plan document and this SPD or Liberty's group insurance contract or Certificate of Coverage address the same issue but are not inconsistent or contradictory, the relevant provisions of such documents shall be read and construed together where possible so as to give such provisions a consistent and intended meaning. Specific provisions in a document shall control over more general provisions in the other plan document, to the extent not prohibited by law. Where there is a direct conflict between the terms of the Plan document and this SPD, and such conflict is not resolved by application of the preceding provisions in this paragraph, the terms of the Plan document shall control.

Benefits described here may also be affected by contracts between Charter and specific employees or employee groups.

Charter Communications, Inc. is hereafter referred to as "Charter" or "the Company."

LONG-TERM DISABILITY PROGRAM BENEFIT HIGHLIGHTS

The Long-Term Disability Program is a fully-insured disability income program for eligible Employees of Charter and other participating Employers. Disability benefits under the Long-Term Disability Program are insured under a group insurance contract issued to Charter by Liberty Life Assurance Company of Boston (sometimes referred to in this booklet as "Liberty"). A copy of the Liberty Certificate of Coverage is attached to this booklet as an Appendix, and contains important, detailed information on coverage, disability income offsets, duration of disability benefits, pre-existing condition exclusions, what constitutes "Disability" or "Partial Disability", and information you may be requested to provide to Liberty to substantiate your illness or injury.

For questions about long-term disability benefits and to submit claims under the Long-Term Disability Program, contact the insurer, Liberty, at the following:

Liberty Life Assurance Company of Boston
Administrative Office
75 Berkeley Street
Boston, MA 02117
Phone: 844-384-5858

Long-Term Disability Program Benefit Highlights	
Weeks Disabled	**Benefit[1]**
You must complete the Elimination Period, which is the greater of (a) the end of your benefits under Charter's Short-Term Disability Program, or (b) twenty-six (26) weeks. The maximum duration of long-term disability benefits is based on age at the time of disability. (See the Schedule of Benefits in the attached Liberty Certificate of Coverage.)	27+ weeks 60% of Basic Monthly Earnings (subject to a maximum monthly benefit of $15,000 reduced by certain other income)

[1]This amount may be reduced by other sources of income or statutory benefits, if applicable. (See *Other Income Benefits and Other Income Earnings* under the section on *Disability Income Benefits* in the attached Liberty Certificate of Coverage.)

Important Note on Eligibility

Employees working in Hawaii and New York who are subject to a collective bargaining agreement (except Kona International Brotherhood of Electrical Workers #1186) are not eligible for benefits under the Long-Term Disability Program described in this SPD.

ABOUT YOUR PARTICIPATION

This section includes important information about your participation in the Long-Term Disability Program.

Who is Eligible

Employee Eligibility

You are eligible to participate in the Long-Term Disability Program if you are classified as an Employee. An "Employee" is an individual classified by Charter of another participating employer (each an "Employer") as a full-time employee who is regularly scheduled to work at least 30 hours per week. If your regularly scheduled hours are reduced below 30 hours per week, you are no longer eligible for coverage under the Long-Term Disability Program. The participating Employers as of the date of this SPD are listed under *Plan Administration*.

Regular, full-time bargaining unit employees may or may not be eligible, depending on the terms of the contract between the bargaining unit and Charter or other participating Employer. Independent contractors, self-employed individuals, directors who are not also regular, full-time employees, temporary employees, certain non-resident aliens and leased employees are not eligible to participate in the Plan or the Long-Term Disability Program.

Eligible Employees' dependents and other family members are neither eligible for nor covered by the Long-Term Disability Program.

When Coverage Begins

Effective January 1, 2017, coverage for eligible Employees under the Long-Term Disability Program begins on the first day after you have completed one year of employment.

If you are not actively at work on the date your coverage is supposed to begin, the effective date of your coverage will be delayed. Prior to July 28, 2017, your coverage will start on the first day of the month following the date you are next actively at work. Effective July 28, 2017, your coverage will start immediately upon your return to work.

If you are a rehired Employee, your rehire date determines when your Long-Term Disability Coverage begins.

- If you are rehired less than 12 months after your termination and you had previously satisfied the waiting period, your disability coverage begins on your rehire date
- If you are rehired less than 12 months after your termination and you had not previously satisfied the waiting period, your prior service will be applied toward the waiting period.
- Otherwise, your disability coverage begins on the first day following one year of employment.

Special coverage or eligibility provisions may apply in the case of corporate transactions such as a merger or acquisition. For example if you are an eligible Employee – that is, you are regularly

scheduled to work at least 30 hours per week – and you were covered by and had satisfied the waiting period for coverage to begin under the separate Long-Term Disability Program maintained under the Time Warner Cable Benefits Plan (i.e., four months of active employment) or the Bright House Networks Disability Plan (i.e., one month of active employment) prior to the merger of those plans into the Charter Communications, Inc. Welfare Benefit Plan on December 31, 2016, then your coverage under the Long-Term Disability Program began on January 1, 2017.

Paying for Coverage

For eligible Employees with base annual earnings of less than $100,000, Charter pays the full cost of insurance premiums under the Long-Term Disability Program. Therefore, any Long-Term Disability Program benefits ultimately paid while Charter pays the cost of coverage will be taxable income.

Eligible Employees with base annual earnings of $100,000 or more must pay for the cost of insurance premiums for coverage under the Long-Term Disability Program. The cost of coverage is deducted from those Employees' pay on an after-tax basis, which results in any Long-Term Disability Program benefits ultimately paid not being subject to federal income tax. (Note that, in many cases, Employees who must pay for their coverage under the Long-Term Disability Program are eligible for additional perquisites which may include additional taxable cash compensation intended to offset the cost of Long-Term Disability Program coverage. Any such perquisites or additional cash compensation is not provided as part of the Plan, and is not subject to the ERISA rights or procedures for claims and appeals described in this SPD. Those supplemental perquisites will be subject to Charter's regular payroll practices, and may be changed at any time.)

When Coverage Ends

For information on when your coverage under the Long-Term Disability Program ends, you should refer to the *Termination Provisions* in the attached Liberty Certificate of Coverage.

PLAN ADMINISTRATION

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about the Plan.

Plan Name and Plan Type

The Charter Communications, Inc. Long-Term Disability Program is a component program under the Charter Communications, Inc. Welfare Benefit Plan (the "Plan"). The Plan is an ERISA welfare benefits plan. The Long-Term Disability Program provides long-term disability benefits.

Plan Sponsor

The name, address and telephone number of the Plan Sponsor are:

Charter Communications, Inc.
12405 Powerscourt Drive
St. Louis, MO 63131-3674
(314) 965-0555

Participating Employers

The following employers are participating Employers as of the date of this SPD:

Charter Communications, Inc.
Charter Communications, LLC

Plan Administrator and Named Fiduciary

The name, address and telephone number of the Plan Administrator and Named Fiduciary are:

Charter Communications, Inc.
12405 Powerscourt Drive
St. Louis MO 63131-3674
(314) 965-0555

The administration of the Plan will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility and coverage under the Plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding on all parties. Any interpretation of the Plan or other action of the Plan Administrator made in good faith in its sole discretion shall be subject to review only if such an interpretation or other action is without a rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of the review. Any employer that adopts and maintains the Plan, and any employee who performs services for an employer that are or may be compensated for in

part by benefits payable pursuant to the Plan, hereby consents to actions of the Plan Administrator made in its sole discretion and agrees to this narrow standard of review.

Agent for Service of Legal Process

Service of legal process may be served on the Plan Sponsor or Plan Administrator at the addresses specified above or upon the Plan Sponsor's registered agent at the following address:

Corporation Service Company
2711 Centerville Road, Suite 400
Wilmington, DE 19808

Identification Number

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to Charter is 84-1496755. The Plan Number for the Plan is 507.

Plan Year

The Plan Year is January 1 through December 31.

Plan Funding

The Long-Term Disability Program is a fully-insured welfare benefit plan.

Claims Administrator and Claims Fiduciary

The Long-Term Disability Program's insurer is responsible for the claims and appeals administrative process. Liberty can be reached at the following address:

Liberty Life Assurance Company of Boston
175 Berkeley Street
Boston, MA 02117

Plan Documents

This booklet is intended to provide you with a summary of the Long-Term Disability Program. It is not the actual Plan document, which governs the operation of the Plan, although the actual Plan document might incorporate some provisions of this booklet by reference. The actual Plan document sets forth all of the details and provisions concerning the Plan and is subject to amendment. Liberty's Certificate of Coverage (attached to this booklet) and group insurance contract for the Long-Term Disability Program govern the operation of the Long-Term Disability Program, and are also subject to amendment. If any questions arise that are not covered in this booklet or if this booklet appears to conflict with the official Plan or group insurance documents, the text of the official Plan or group insurance documents, as applicable, will determine how such questions will be resolved. If the terms of the Plan document, this SPD, or the attached Certificate of Coverage differ from the Liberty group insurance contract, the group insurance contract will govern.

Future of the Plan

It is Charter's intent that the Plan will continue indefinitely. However, Charter reserves the right to amend, modify, suspend or terminate the Plan and the Long-Term Disability Program in whole or in part. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, without advance notice thereof. Benefits described here may also be affected by contracts between Charter and specific employees or employee groups.

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to your creditors or anyone else.

Limitation on Actions and Venue

No action shall be brought against the Plan or Liberty in any court unless the ERISA Claim Processing Procedures described in this SPD have been fully exhausted. A participant, beneficiary or claimant asserting any action under 29 U.S.C. § 1132, 29 U.S.C. § 1140 or any other provision of the Employee Retirement Income Security Act of 1974, as amended, shall do so, if at all, within one year after the cause of action accrued. A cause of action shall be deemed to have accrued the earliest of when the participant, beneficiary or claimant has exhausted his administrative remedies under the Plan, when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to the participant's, beneficiary's or claimant's written request, when the claimant first was advised that he was an independent contractor, or when the participant, beneficiary or claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this time frame shall preclude a participant, beneficiary or claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of the Employee Retirement Income Security Act of 1974, as amended, by a participant or beneficiary under the Plan or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

CLAIM PROCESSING AND YOUR RIGHT TO APPEAL

Filing a Long-Term Disability Claim

The Long-Term Disability Program is a component program of the Charter Communications, Inc. Welfare Benefit Plan, which is an Employee Retirement Income Security Act of 1974 (ERISA) plan and subject to the claims procedures applicable to disability benefits. All claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Eligibility Determination

Determinations of eligibility to participate in the Long-Term Disability Program will be made by the Plan Administrator rather than the Claims Administrator, but will generally follow the same process as claims decisions outlined in this section. If you have questions about your eligibility, you should contact the Charter Benefits Center at 877-892-2367. If you would like to request a formal determination of your eligibility to participate in the Long-Term Disability Program or believe that a determination of your eligibility to participate in the Long-Term Disability Program was incorrect, please contact:

Claims & Appeals Management – Charter Communications, Inc.
P.O. Box 1407
Lincolnshire, IL 60009-1407
Fax: 847-554-1808

877-892-2367 (to request a claim form)

Reporting a Long-Term Disability Claim

Liberty Assurance Company of Boston is the "Claims Administrator" and claims fiduciary with sole authority to determine benefit claims under the terms of the Long-Term Disability Program. If you have a claim under the Long-Term Disability Program, you should notify the Claims Administrator as soon as possible but no later than 20 days after the date of your disability. You may designate a representative to act on your behalf in pursuing a claim or appeal, but this designation must be explicitly stated in writing. If you would like to designate a representative, you will need to contact the Claims Administrator.

When the Claims Administrator receives your claim, you will be sent claim forms. If the forms are not received within 15 days after written notice of the claim is sent, you can send the Claims Administrator written Proof (as defined in the attached Certificate of Coverage) of your claim without waiting for the forms. Satisfactory Proof of loss must be provided to the Claims Administrator no later than 90 days after the end of the Elimination Period described in the Certificate of Coverage. Failure to furnish such Proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such Proof within such time. Such Proof must be furnished to the Claims Administrator as soon as reasonably possible, and in no event, except in the absence of legal capacity of the claimant, later than one year from the time Proof is otherwise required.

Proof of continued loss, continued Disability or Partial Disability, when applicable, and Regular Attendance of a Physician (each as defined in the Certificate of Coverage) must be provided to the Claims Administrator of the request for such Proof. Liberty reserves the right to determine if your Proof of loss is satisfactory.

You may be required to give the Claims Administrator your authorization to obtain additional medical information from your health care provider. You may also be required to provide other medical or non-medical information in support of your claim for disability benefits. For example, you may be asked by the Plan Administrator or the Claims Administrator to furnish proof of your continued disability or objective evidence of the diagnosis, treatment, and/or presence of other health conditions, injuries of illness. If you do not give your authorization or provide other medical or non-medical information as requested, the Claims Administrator may deny your claim or stop sending you payments.

Claims Timeline

Within 45 days after you have filed a written claim with the Claims Administrator, the Claims Administrator will notify you of its decision. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the necessary information accompanies the filing. If the Claims Administrator needs more time to examine your request because of matters beyond the control of the Claims Administrator, you will be informed within these 45 days that additional time is needed, why it is needed and the date by which you can expect to receive a decision.

Consideration of your request may be extended twice (by 30 days each time) if it is determined that each extension is necessary due to matters beyond the Claims Administrator's control and you are notified of these circumstances in advance. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension will begin after you have provided that information. If your claim is wholly or partially denied, the Claims Administrator will provide a written explanation in accordance with ERISA.

If your claim is approved, disability payments will be made to you. If benefits are denied for any reason, you have the right to appeal the denial. See *Your ERISA Rights to Appeal a Long-Term Disability Denial* below.

Once benefits start, the Claims Administrator reserves the right to request periodic reexaminations to verify your continuing disability. If the Claims Administrator requests the periodic reexamination, the costs associated with that reexamination are paid by Liberty.

Your ERISA Rights to Appeal a Long-Term Disability Denial

If your claim is denied, you have the right to appeal your denial. A claim denial notice will include:

- The specific reason or reasons for the denial;
- The specific Plan or Long-Term Disability Program provisions on which the determination is based;
- A description of the Plan's internal claim and appeals procedures (including the time limits applicable to such procedures) and a statement regarding the claimant's right to bring a civil action under ERISA following a final adverse determination on review;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- If the claim is denied based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Long-Term Disability Program to your medical circumstances, or a statement that such explanation will be provided upon request; and
- A description of any internal rule, protocol or similar criterion that the Claims Administrator relied on to deny the claim and a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

Your disability plan allows for one appeal of your denied claim. It will be important for you to submit all relevant documentation when you request your appeal.

Appeal Procedure

You may appeal a denied claim within 180 days following an adverse benefit determination. In most cases, the Claims Administrator will review and decide on the appeal within 45 days of receipt of your written request. The period of time within which a benefit determination on review is required to be made shall begin upon receipt of the written request, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, the Claims Administrator may notify you there is a special circumstance which requires a delay and provide the date by which the administrator expects to render the determination on review. There may be a limited extension (not to exceed 45 days) of the review and decision-making process. If an extension is necessary to decide the appeal, the notice of extension will specifically describe the required information. If you deliver the requested information within the time period specified, the 45-day extension of the appeal period will begin after you have provided the information.

You will be provided a full and fair review. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You will have the opportunity to submit relevant written comments, documents, records or other information in support of your appeal. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. The review will be conducted by the Claims Administrator and will be made by a

person different from the person who made the initial determination, and such person will not be the original decision-maker's subordinate.

In the case of a claim denied on the grounds of a medical judgment, the Claims Administrator will consult with a health care professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Claims Administrator in connection with the denial of your claim, the Claims Administrator will provide you with the names of each such expert, regardless of whether the advice was relied upon.

Appeal Timeline

Within 45 days after you have filed a written appeal with the Claims Administrator, the Claims Administrator will notify you of its decision. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the necessary information accompanies the filing. If the Claims Administrator needs more time to examine your request because of matters beyond the control of the Claims Administrator, you will be informed within these 45 days that additional time is needed, why it is needed and the date by which you can expect to receive a decision.

Consideration of your request may be extended twice (by 30 days each time) if it is determined that each extension is necessary due to matters beyond the Claims Administrator's control and you are notified of these circumstances in advance. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension will begin after you have provided that information. If your claim is wholly or partially denied, the Claims Administrator will provide a written explanation in accordance with ERISA. An appeal denial notice will include:

- The specific reason or reasons for the denial;
- The specific Plan or Long-Term Disability Program provisions on which the determination is based;
- A description of any voluntary appeal procedures offered by the Claims Administrator and the claimant's right to obtain information about such procedures (including the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what might be available is to contact your local U.S. Department of Labor Office and your state's insurance regulatory agency.");
- A statement regarding the claimant's right to bring a civil action under ERISA section 502(a);

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

- If the appeal is denied based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Long-Term Disability Program to your medical circumstances, or a statement that such explanation will be provided upon request; and

- A description of any internal rule, protocol or similar criterion that the Claims Administrator relied on to deny the appeal and a statement that a copy of this rule, protocol or similar criterion will be provided to the claimant free of charge upon request.

Exhaustion of Claims and Appeals Process

Upon completion of the claims and appeals process, you will have exhausted your administrative remedies under the Long-Term Disability Program. No action at law or in equity may be brought with respect to Long-Term Disability Program benefits until all rights under the Long-Term Disability Program have been exhausted and any such action must be brought no later than one year from the date the Plan Administrator's or Claims Administrator's final decision upon review of an appeal or the expiration of the applicable limitations period under applicable law (whichever is earlier).

Time Limit on Legal Actions Following the Denial of an Appeal

Any legal action brought by a claimant following exhaustion of the Long-Term Disability Program's claims and appeals process must be brought within one year following the claimant's receipt of the denial of the claimant's claim for benefits on appeal, or such claim shall be forfeited and forever barred by the Plan's limitation on the time period during which such legal actions may be commenced.

Claim or Eligibility Fraud

The Claims Administrators may evaluate claims to detect fraud or false statements and may notify Charter regarding these matters. If a claim has been submitted for payment or paid by the Plan as a result of fraudulent representation, the Claims Administrator or the Plan Administrator, in its discretion, may seek reimbursement and may elect to pursue the matter by pressing criminal charges to the maximum extent allowable by law.

YOUR RIGHTS UNDER ERISA

As a participant in the Charter Communications, Inc. Welfare Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan and the Long-Term Disability Program, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and Program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Long-Term Disability Program or the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR EMPLOYMENT

Your eligibility or your right to benefits under the Plan should not be interpreted as a guarantee of employment. The Company's employment decisions are made without regard to the benefits to which you are entitled upon employment.

This document provides detailed information about the Long-Term Disability Program and how it works. Nothing in this SPD or in any other written or oral communication made at the time of hire and during the course of employment by any representative of the Company or a participating Employer shall create or is intended in any way to create a contract of employment, express or implied.